STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2007

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WINSOR HOUSE CONVALESCENT HOSPITAL	101 S ORCHARD AVE, VACAVILLE, CA 95688 SOLANO COUNTY

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	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit. Representing the Department of Public Health: Edwin Hoffmark, HFEN CLASS AA CITATION -- PATIENT CARE 11-1872-0003860-F Complaint(s): CA00074799, CA00078508 F323 §483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. F324 §483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent			

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	Continued From page 1 accidents. The facility failed to ensure that Resident 1's environment was free of accidents hazards by allowing the resident to use a Merry Walker type device (an enclosed framed wheeled walker with a posterior seat made with white polyvinyl chloride [PVC] pipe) without having knowledge or access to manufacturers' safety recommendations or a facility policy or procedure for use of this device. In addition, the facility failed to provide adequate supervision of Resident 1 while ambulating in the Merry Walker type device, which resulted in the resident suffering multiple falls while in the device. Resident 1's last fall, not witnessed, on 3/10/06, resulted in blunt force head and neck injuries that caused his death.			

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	Continued From page 2 Resident 1 was an 88-year-old male admitted to the facility on 2/23/05. His medical history included Alzheimer's disease, Sick Sinus Syndrome (a heart conduction condition), congestive heart failure and lack of a right eye. A Minimum Data Set (MDS) assessment dated 2/21/06 documented that he had short and long term memory problems, severe cognitive impairment, periods of altered perception or awareness of surroundings, periods of restlessness, rarely able to make himself understood and sometimes able to understand others. He had severely impaired vision, wandered daily and required supervision while walking. His balance was unsteady, but was able to correct his balance without physical support. Resident 1's care plan for fall prevention, initiated on			

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	Continued From page 3 2/23/05, noted his fall risks to be related to his disorientation to person, place and time, being chair bound, poor vision, gait disturbance and the type of medications he was taking. The stated goal was that he would remain free of injury, falls or accidents. The documented approaches were: 1. Monitor for factors causing prior falls. 2. Answer calls quickly; anticipate needs 3. Provide activities that minimize risk for falls while meeting other needs 4. Call light within reach 5. Keep personal care items within reach of resident 6. Remind resident to ask for assistance and not to attempt unassisted transfers Review of the clinical record nursing notes and the facility's investigative reports on 12/20/06, revealed documentation that Resident 1 fell on 6/13/05, tipping the			

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	Continued From page 4 Merry Walker type device over onto the ground, no injuries were noted. On 7/4/05, Resident 1 again fell while in the Merry Walker type device, no injuries were noted. Record review on 12/20/06, revealed that on 10/17/05 at 11:55 a.m., Resident 1, turned around in the Merry Walker type device, tipped it over, and fell sustaining a laceration to his right elbow that required sutures. Care plan interventions, for this fall, were documented as follows: 1. Notify M.D. 2. Notify family- discuss risks vs. benefits of more restrictive measures 3. Treatment/assess right elbow laceration every day 4. Physical Therapy screen 5. Will use two pull-tabs (an alarm system designed to alert staff when a tab is pulled out of the unit) when in w/c			

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	Continued From page 5 (wheelchair) to alert staff to when he is getting turned around (sic). No interventions were included regarding Resident 1's fall risk while in the Merry Walker type device. All documented falls that Resident 1 sustained from 6/13/05 to 3/10/06 were while in the Merry Walker type device. Fall risk assessment score, dated 10/17/05, was 20. A fall risk assessment greater than 10 indicates a high fall risk. Documentation regarding staff monitoring and/or supervision of Resident 1 while ambulating in the Merry Walker type device was not found in the clinical record after the 10/17/05 fall. In addition, staff supervision and/or monitoring while ambulating in the Merry Walker type device was not included as an intervention in			

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	Continued From page 6 Resident 1's care plan. Record review on 12/20/06, revealed that on 11/26/05 at 9:20 p.m., Resident 1 was found lying on his left side on the floor beside his merry walker type device. This fall was not witnessed. Care plan interventions for this fall were documented as follows: 1. M.D. aware 2. Family aware 3. Tab alarms present on Merry Walker (first care plan notation 4/4/05) 4. Monitor whereabouts 5. Rehabilitative Nursing Aide (RNA) as ordered 6. Vital Signs every shift as facility (sic) 7. Monitor neuro checks 8. Notify M.D. as needed			

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	Continued From page 7 The fall risk assessment, dated 11/05 (no day of the month documented), was not finished and lacked a total score. Other than, to monitor Resident 1's whereabouts, documentation regarding the monitoring of Resident 1 while in the Merry Walker type device was not found in the clinical record after the 11/26/05 fall. The Resident Assessment Protocol Summary (RAPS) dated 2/22/06, indicated that Resident 1 had a significant cognitive impairment, a severe communication deficit and severe vision loss. Resident 1 did follow simple Spanish spoken commands at times. Resident 1 was at risk for not understanding or communicating needs. The RAPS went on to indicate that the resident was ambulatory in the "Merry Walker" with tabs alarm unit and that he wandered with no purpose due to cognitive			

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	Continued From page 8 deficit. In addition, documentation revealed that Resident 1 was unable to understand instructions and did not participate in Activities of Daily Living (ADL) care. He was fully dependent on staff for Activities of Daily Living. Resident 1 was able to move around in bed and needed limited assistance when he first got up, but once he was in the "Merry Walker" he was independent with oversight supervision of whereabouts due to non-purposeful direction, and he needed encouragement to rest. There was no documentation in the clinical record or facility record as to the definition of "oversight supervision." Staff A stated that oversight supervision was her term for staff to "keep an eye" on Resident 1. Staff A stated that the resident "knew" if someone was near him and then he would act out, verbally and/or physically. Staff A was			

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	Continued From page 9 unable to provide documentation including care planning of Resident 1's acting out when staff were around him. The resident's care plan for Altered Thought Process was revised on 2/22/06. The revision included the following statements: Bumps into walls and doorways. Ambulates along walls, wanders into doors if they are open. The added approach for this concern was to: approach resident in calm tone due to increased behavior when redirected. The resident care plan for Potential for Elopement was revised on 2/22/06. The revision included the following statements: "Wanders without purpose in Merry Walker. Wanders in and out of Rooms. Wanders close to the outside doors. Has wander guard on at all times. Resident resistant to redirection, use simple commands in Spanish." Two of the ten approaches to this concern			

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	Continued From page 10 were: Check whereabouts frequently and oversight supervision during ambulation. The resident care plan for Potential for injury (initiated 3/6/05, revised 6/6/05 and 2/22/06), documented: The resident has no safety awareness and wanders without purpose. The fall assessment score was 17. Least restrictive assist device. Merry Walker with tab unit. Severe Vision deficit, right eye missing, left eye follows objects at time. Ambulates along walls and will get into doors if open. The documented approaches were: Provide safe environment. Unable to use call light, please check frequently. Bed in lowest position while resident is in it. Monitor pain level every shift.			

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	Continued From page 11 Supervise transfers. Labs as ordered, report abnormals to MD. Medicate for pain as ordered. Merry Walker while out of bed. Merry Walker with tabs unit. Supervised oversight when ambulate independently. Encourage resident to keep walker on ground. Encourage and redirect when resident is walking sideways in Merry Walker. Refuses to wear shoes, grip sock to be worn at all times. Review of facility documentation on 12/20/06, revealed that on 3/10/06 at 8:30 p.m., staff heard the sound of a resident falling. Staff found Resident 1 lying on the floor with the Merry Walker type device tipped over as well. Resident 1 was half way inside the walker, his face was on the floor turned towards the left side with blood noted.			

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	Continued From page 12 There were two documented lacerations on the right forehead and staff noted a bruise on the resident's left temple. Review of Staff A's written statement, dated 3/12/06, revealed that Resident 1's fall on 3/10/06 was while in the Merry Walker type device and was not witnessed. Review of Staff D's written statement, dated 3/12/06, revealed that Resident 1's fall on 3/10/06 was while in the Merry Walker type device and was not witnessed. The resident was transferred to a general acute care hospital. Review of the Emergency Department's nursing assessment, dated 3/10/06 at 9:20 p.m., revealed that Resident 1 sustained three lacerations to the forehead and swelling was noted on the left temple region. The reports of the Computerized Tomography (CT) exam			

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	Continued From page 13 performed on 3/10/06 at 10:55 p.m., documented that the resident had fractures of the C1 and C2 spine and a nondisplaced right parietal skull fracture. The first hospital transferred Resident 1 to another hospital on 3/11/06. Resident 1 expired on 3/11/06. The Coroner's final report of investigation, dated 5/8/06, documented that the "Decedent fell while walking in care facility, on 3/10/06, at 20:15 hours, cause of death: Blunt force head and neck injuries." Staff A stated during an interview on 12/20/06 at 8:40 a.m., that the facility had several conversations with Resident 1's family members regarding the risks vs. benefits of using the Merry Walker type device. Staff A stated that the family members wanted Resident 1 to be able to continue walking, something that might be lost if Resident 1 were to be in a more restrictive device, such			

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	Continued From page 14 as a wheelchair with a lap buddy. When asked if other methods to protect the resident from falls in the Merry Walker type device were discussed with the family, Staff A replied that she didn't think so. Staff B stated in an interview on 3/26/07 at 10:50 a.m., that one always had to watch Resident 1 when he was in the Merry Walker type device. Review of Merry Walker manufacturer's recommendation, undated, on 3/26/07, revealed that the Merry Walker Corporation does not currently manufacture Merry Walkers made of PVC pipe as they tip easily and are not bottom weighted. In addition, the Merry Walker Corporation recommends the use of a wide, tapered strap that extends from the hand rail in front of the device, down between the legs of the resident and attaches under the posterior seat to prevent the resident from			

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	Continued From page 15 twisting while walking in the Merry Walker. Observation of the Merry Walker type device used by Resident 1, as confirmed by Staff C, on 4/11/07 at 9 a.m. revealed a device made from PVC type pipe, without a weighted bottom and with an approximately 2 inch strap, extending from beneath the seat to the hand rail in front. Staff E stated in an interview on 8/1/07 at 3:30 p.m., that the facility staff could not find a policy or procedure for the use of the Merry Walker type device that was in use at the time of Resident 1's fall. The facility failed to ensure that Resident 1's environment was free of accident hazards by allowing Resident 1 to use a Merry Walker type device without benefit of the manufacturers' safety recommendations/requirements or a facility policy/procedure for the use of the device. In			

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	Continued From page 16 addition, the facility failed to provide adequate supervision for Resident 1 while using the Merry Walker type device which resulted in Resident 1 suffering multiple falls. Five consecutive falls from 6/13/05 - 3/10/06 were while Resident 1 was in the Merry Walker type device and Resident 1 sustained injuries in the last three falls. The last two falls were unwitnessed. Resident 1's last fall on 3/10/06 resulted in a skull fracture and neck fractures which was the cause of Resident 1's death. These failures presented either imminent danger that death or serious harm would result or a substantial probability that death or serious harm would result and was a direct proximate cause of the death of the patient.			

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